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Issue Date: 08 December 2006

CASE NO.: 2005-BLA-00070

In the Matter of:

G. M.,
Claimant,

v.

DOMINION COAL CORPORATION,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

Appearances:

G. M.,
Pro se Claimant

Ronald E. Gilbertson, Esquire
For the Employer

Before: Stephen L. Purcell
Administrative Law Judge

DECISION AND ORDER – AWARDING BENEFITS

This case arises from a claim for benefits under the "Black Lung Benefits Act," Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. §901, *et seq.* (hereinafter referred to as "the Act"), and applicable federal regulations, mainly 20 C.F.R. Parts 718 and 725 ("Regulations").

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis or to the survivors of persons whose death was

caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as black lung.[1]

A formal hearing in this case was scheduled in Abingdon, Virginia for January 12, 2006, but Claimant asked that the hearing be cancelled and a decision be issued on the record. Claimant's unopposed request was granted in an order dated December 29, 2005. Both parties were thereafter allowed to submit additional evidence, and written closing arguments were to be filed within forty-five days of April 12, 2006. Claimant's closing brief was received on May 31, 2006. No brief was filed by Employer. Director's exhibits 1-119, Claimant's exhibits 1 and 2,[2] and Employer's exhibits 1 and 2[3] are hereby admitted without objection.

The Findings of Fact and Conclusions of Law that follow are based upon my analysis of the entire record, arguments of the parties, and the applicable regulations, statutes, and case law. Although perhaps not specifically mentioned in this decision, each exhibit and argument of the parties has been carefully reviewed and thoughtfully considered. While the contents of certain medical evidence may appear inconsistent with the conclusions reached herein, the appraisal of such evidence has been conducted in conformance with the quality standards of the regulations.

ISSUES

The contested issues are:

1. Whether the claim is timely;
2. Whether Dominion Coal Corporation is the Responsible Operator;
3. Whether Claimant has pneumoconiosis;
4. Whether pneumoconiosis arose out of coal mine employment;
5. Whether Claimant has a totally disabling pulmonary impairment; and
6. Whether Claimant's total disability is due to pneumoconiosis;
7. Whether Claimant has established a material change in condition pursuant to § 725.309;
8. Whether Claimant or Employer have established a material change in condition or mistake of fact pursuant to § 725.310. DX 54, 92, 116, 110.

[1] The following abbreviations have been used in this opinion: DX = Director's exhibits; EX = Employer's exhibits; CX = Claimant's exhibits; BCR = Board-certified radiologist; and B = B-Reader.

[2] CX 1, received on January 24, 2006, is a copy of Claimant's marriage certificate showing that he was married to Lucille L. Osborne on October 26, 2005. CX 2 is a medical report prepared by Dr. Joshua Perper and was received on January 30, 2006.

[3] EX 1 is a transcript of the January 6, 2006 deposition of Dr. James R. Castle which was received March 14, 2006. EX 2 is a transcript of the March 27, 2006 deposition of Dr. Gregory J. Fino which was received April 6, 2006.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History and Factual Background[4]

Claimant, G. M., filed his first claim for black lung benefits on March 2, 1982. DX 1a. On December 5, 1983, a claims examiner issued a "Notice of Initial Findings" in which she concluded that Claimant was not entitled to benefits. Claimant thereafter filed a request for formal hearing, and the claim was forwarded to the Office of Administrative Law Judges ("OALJ") on June 26, 1985. A formal hearing was held before Administrative Law Judge Aaron Silverman on November 18, 1985 in Abingdon, Virginia, and Judge Silverman thereafter issued a decision dated January 30, 1987 denying benefits based on his conclusion that, although Claimant established he suffered from pneumoconiosis, he had not shown that he was totally disabled by that disease. *Ibid*. Claimant appealed the decision, and the Benefits Review Board issued a decision dated August 31, 1988 affirming Judge Silverman's decision.

On May 2, 1989, Claimant sought modification of the decision denying benefits. DX 1a. He was notified by letter dated October 12, 1989 that his request for modification was denied. Claimant filed a request for a formal hearing dated October 25, 1989, and the claim was again forwarded to OALJ on January 17, 1990. A formal hearing was held September 24, 1991 in Abingdon, Virginia. Administrative Law Judge Clement J. Kichuk subsequently issued a decision and order dated February 20, 1992 denying modification because Claimant failed to establish any change in his medical condition.

Claimant once again sought modification of the decision denying benefits in a letter dated December 22, 1992, and he attached to his request additional medical evidence in support of his claim. DX 1a. In a letter dated August 16, 1993, a claims examiner notified Claimant that the prior findings supporting denial remained unchanged and that his request for modification was therefore denied. In a letter dated September 9, 1993, Claimant noted his objection to that decision and requested a hearing before OALJ. After additional evidence was received from the parties, the District Director issued a "Memorandum of Informal Conference" dated November 23, 1993 in which he concluded that Claimant failed to establish either a change in condition or a mistake in a determination of fact. Claimant again requested a formal hearing in a letter dated December 3, 1993, and the claim was thereafter forwarded to OALJ on March 8, 1994. A hearing was held on November 1, 1994 in Abingdon, Virginia. Administrative Law Judge Nicodemo DeGregorio thereafter issued a decision dated June 28, 1995 in which he found that Claimant was totally disabled but that such disability was not due to pneumoconiosis. No further action was taken by Claimant, and the decision of Judge DeGregorio denying benefits thus became final.

Claimant filed the instant duplicate claim for benefits on August 25, 1999. DX 1. On April 5, 2000, the District Director found Claimant entitled to benefits. DX 23. In a letter dated April 12, 2000, Employer noted its objection to the determination and asked for a formal hearing

[4] Given the filing date of this claim, subsequent to the effective date of the permanent criteria of Part 718, (*i.e.* March 31, 1980), the regulations set forth at 20 C.F.R. Part 718 will govern its adjudication. Because the miner's last exposure to coal mine dust occurred in Virginia this claim arises within the territorial jurisdiction of the United States Court of Appeals for the Fourth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989).

before OALJ. DX 25. On October 19, 2000, a hearing was held in Abingdon, Virginia before Administrative Law Judge Mollie Neal. DX 36. On July 9, 2001, Judge Neal issued a decision and order denying benefits based on her determination that evidence submitted since the denial of Claimant's prior claim was insufficient to support a finding that he had complicated pneumoconiosis or that he was totally disabled because of pneumoconiosis. DX 43. Claimant appealed Judge Neal's decision on July 27, 2001, and the Benefits Review Board subsequently issued an order dated October 10, 2001 directing Claimant to show cause why his appeal should not be dismissed for failure to file a brief. DX 44; DX 49. Claimant responded to the Board's show cause order on October 23, 2001, and the Board thereafter issued a decision and order affirming Judge Neal's decision on June 28, 2002.[5] DX 50; DX 56.

In a letter dated June 5, 2003, Claimant requested modification of the denial of his duplicate claim and submitted additional medical evidence in support of such request. DX 54. The District Director acknowledged receipt of Claimant's modification request in a letter dated June 26, 2003, and thereafter issued a proposed order to show cause, granting request for modification on February 2, 2004. DX 57; DX 78. Employer objected to the proposed order granting modification in a letter dated February 17, 2004 and submitted additional evidence. DX 81. On June 8, 2004, the District Director issued a proposed decision and order granting Claimant's request for modification, and Employer thereafter objected to the decision and requested a formal hearing before OALJ. DX 92; DX 94.

In a letter dated July 16, 2004 letter, Employer requested modification of the District Director's proposed decision and order granting modification and submitted additional medical evidence. DX 97. On October 25, 2004, a claims examiner noted receipt of Employer's request and allowed thirty days for the submission of additional evidence. DX 99. In a letter dated November 1, 2004, Claimant acknowledged receipt of the claims examiner's October 25, 2004 letter and requested that she amend the letter to reflect that Employer had requested a hearing before OALJ and not requested modification. DX 101. On January 5, 2005, the claims examiner responded that Employer had indeed requested modification and that the request was handled properly. DX 102. In another letter dated January 14, 2005, Claimant asserted that Employer's request for modification represented its agreement with the June 8, 2004 proposed order granting Claimant's request for modification and that Claimant was thus entitled to benefits. DX 104. In a January 24, 2005 letter to the claims examiner, Employer stated that: the June 8, 2004 proposed decision had never become final; it continued to dispute Claimant's entitlement to benefits; and "[y]our office is authorized to reconsider that order and to correct the mistakes of fact contained in it." DX 105. Additional medical evidence was thereafter submitted by both parties, and a proposed decision and order denying Employer's request for modification was issued on March 21, 2005. DX 106-108. In a letter dated March 30, 2005, Employer noted its objections to that decision and requested a formal hearing before OALJ. DX 110. The claim was thereafter forwarded to OALJ by the District Director on June 28, 2005. DX 116.

[5] The Board *sua sponte* reconsidered its decision and subsequently issued a decision and order on reconsideration dated July 24, 2003 in which it modified footnote 1 of the decision. DX 62. No substantive changes were made to the prior decision.

Medical Evidence

The medical evidence submitted by the parties prior to June 28, 2001 has been summarized in the decision of that date issued by Administrative Law Judge Mollie Neal, and her description of that evidence is incorporated herein by reference. DX 43. The medical evidence submitted since then consists of the following:

Chest X-rays[6]

Exhibit Number	Date of X-ray	Physician/ Qualifications	Film Quality	Diagnosis
DX 54	2-5-02	Alexander BCR, B	2	2/1, p/q, 6 zones, Category C. Complicated CWP – summed diameters of large opacities are greater than 50 mm but less than the equivalent area of the right upper zone.
DX 54[7]	2-5-02	Patel		Extensive interstitial lung disease as well as several small to moderate sized soft tissue areas of opacification mainly involving the peripheral portion of the right upper and left mid lung zone most likely indicative of complicated pneumoconiosis. However, possibility of malignant process merely on the basis of chest radiographs can not be totally excluded.
DX 64	2-5-02	Barrett, BCR, B	1	1/2, q/p, 4 zones, Category B
DX 68	2-5-02	Scott, BCR, B	1	No pneumoconiosis. Peripheral infiltrates extending to pleura right

[6] A chest x-ray may indicate the presence or absence of pneumoconiosis. 20 C.F.R. § 718.102(a), (b). It is not utilized to determine whether the miner is totally disabled, unless complicated pneumoconiosis is indicated wherein the miner may be presumed to be totally disabled due to the disease. The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1/2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Similarly, a reading of 0/0 means the doctor found no opacities and did not see any marks that would cause him or her to seriously consider category 1.

[7] The narrative report of Dr. Dilip Patel regarding the February 5, 2002 x-ray is not classified according to the provisions of 20 C.F.R. § 718.102 of the regulations, nor are the medical qualifications of Dr. Patel relating to the interpretation of x-rays contained in the record.

Exhibit Number	Date of X-ray	Physician/ Qualifications	Film Quality	Diagnosis
				mid and upper lung, left mid-lung. Possible 2 cm mass near left hilum, cannot r/o cancer. Advise CT. No small rounded opacities to suggest silicosis/CWP.
DX 72	2-5-02	Navani, BCR, B	3	1/1, t/u, 6 zones, Category B. Scattered densities bilaterally either represent rheumatoid pneumoconiosis or metastatic disease.
DX 81	2-5-02	Wheeler, BCR, B	1	No pneumoconiosis. Chest PA – 6 cm long and 3 cm thick mass right lateral pleura near scapula and masses in lateral left mid lung or pleura and small mass in lateral periphery right mid lung or pleura compatible with inflammatory disease more likely than cancer. 2 cm mass at level of lateral portion left hilum. No other abnormality.
DX 54[8]	3-24-03	Ramakrishnan, BCR, B		Lung fields show small round opacities throughout both lung fields with coalescing nodules and large pulmonary nodules in the upper and mid lung zones on both sides. Distortion of the hila are noted on both sides by the fibrosis. Overall the findings are suggestive of pneumoconiosis of category Q/P, 2/2, large opacity category B, ax, di. When compared with the previous studies of 02/05/02 no significant interval changes are seen.
DX 64	3-24-03	Barrett, BCR, B	1	1/2, q/p, 4 zones, Category B
DX 68	3-24-03	Wheeler, BCR, B	1	No pneumoconiosis. Chest PA – 6 cm long and 3 cm thick mass right lateral pleura near scapula and masses in lateral left mid lung or pleura and small mass in lateral

[8] The chest x-ray interpretation of Dr. Mannachanallur R. Ramakrishnan, although not contained in the standard ILO form, is classified in accordance with the requirements of 20 C.F.R. § 718.102, *i.e.*, he classified the type and profusion of the small opacities observed in the x-ray as q/p and 2/2, respectively, and he noted the presence of a Category B large opacity. Furthermore, Dr. Ramakrishnan's curriculum vitae is contained in the record and shows that he is both Board-certified in radiology and is a NIOSH certified B-reader. DX 54.

Exhibit Number	Date of X-ray	Physician/ Qualifications	Film Quality	Diagnosis
				periphery right mid lung pleura compatible with inflammatory disease more likely than cancer. No other abnormality. No silicosis or CWP.
DX 73	3-24-03	Navani, BCR, B	3	1/1, t/r, 6 zones, Category B. Scattered densities bilaterally are likely to be due to rheumatoid pneumoconiosis. Fibrotic nodules as metastatic disease.
DX 81	3-24-03	Scott, BCR, B	1	No pneumoconiosis. Bilateral peripheral infiltrates right mid and upper lung and left mid-lung. This is probably granulomatous disease unchanged since 5 Feb 02. No small rounded opacities to suggest silicosis/cwp.
DX 69	9-26-03	Fino, B	1	No pneumoconiosis; 2/1, q/t, 6 zones.
DX 70	9-26-03	Scott, BCR, B	1	No pneumoconiosis. Bilateral infiltrates with prominent peripheral component in mid and upper lungs; possible tb or sarcoid. I do not see a small rounded nodular pattern to suggest silicosis/cwp. Old left AC separation.
DX 70	9-26-03	Wheeler, BCR, B	1	No pneumoconiosis. Chest PA/Lateral – 5x3 cm mass lateral RUL involving pleura. Two 3 cm masses lateral left mid and upper lung and 1 in lateral right mid lung or pleura compatible with inflammatory disease more likely than cancer. Subtle infiltrate lower right apex and lateral half RUL and possibly in lateral left mid lung. Check clinically for active inflammatory disease. Healed fracture lateral right rib2 [sic] and healed trauma left acromioclavicular joint. Minimal tortuosity descending thoracic aorta.
DX 107	9-26-03	Alexander, BCR, B	1	2/2, p/q, 6 zones, Category B. Bilateral large opacities indicating category B complicated CWP.

Pulmonary Function Studies

Exhibit	Date	Age	Height[9]	FEV 1	MVV	FVC	Qualify?
DX 54	2-4-02	67	67"	1.71 1.85*		3.30 3.83*	No No
DX 54	5-13-03	68	67"	1.73 1.75*		3.31 3.28*	Yes Yes
DX 69[10]	9-26-03	68	66"	1.44 1.64*		3.09 3.36*	Yes Yes

*Post-bronchodilator

Arterial Blood Gas Studies

Exhibit	Date	PO2	PCO2	Qualify?
DX 69	9-26-03	82.5	44.0	No

*Exercise

Medical Reports

Dr. German Iosif

Dr. Iosif authored a letter dated May 15, 2003 outlining his examination of Claimant that date. DX 54. He noted that Claimant had a previous history of coal mine employment of many years and that he had been found to have widespread pulmonary nodular opacities involving mostly the upper lung zones. Claimant was reported to be a nonsmoker without any history of serious pulmonary infectious disease and no occupational history other than coal mine employment. Dr. Iosif noted that chest x-rays taken as recently as March 24, 2003 were reported by a B-reader as showing features of complicated CWP. Histoplasma antibody titers were obtained by Dr. Iosif and found to be negative for disease, and an intermediate strength PPD injection in the right forearm was negative for tuberculosis. Dr. Iosif opined that Claimant's radiographic features were consistent with those of complicated coal workers' pneumoconiosis. He stated that there were no other plausible explanations for the radiographic abnormalities and that "history and ancillary studies have ruled-out any alternative diagnostic considerations." He concluded that Claimant was totally disabled by his occupational complicated pneumoconiosis from a statutory standpoint.

In a letter dated December 24, 2003, Dr. Iosif states that Claimant had undergone a CT-guided needle biopsy of one of many prominent mass lesions in his upper lung zones. DX 76.

[9] The height is indicated as recorded by each physician. The ALJ is required to resolve the height discrepancies contained in the record. *Protopappas v. Director*, *OWCP*, 6 BLR 1-221 (1983). Since two of the three reported heights (rounded to the nearest hundredth) were recorded as 67 inches, this height is adopted for purposes of this decision.

[10] Dr. John Michos, who is Board-certified in internal and pulmonary medicine, found the 9/26/03 vent study to be acceptable. DX 74, 75.

He wrote: As [Claimant's] pulmonologist, I have though [sic] all along that his radiographic features are those of complicated Coal Workers' Pneumoconiosis. I have conducted extensive investigations for the possibility of tuberculosis or fungal infection with negative results and the patient indeed has no symptoms of active infection or inflammation." *Ibid*. Based on his review of the biopsy report, Dr. Iosif concluded that Claimant had large fibrotic conglomerates consistent with complicated coal workers' pneumoconiosis. He found no clinical or pathological basis for diagnostic consideration of sarcoidosis, tuberculosis, or any other disease.

Dr. Iosif is Board-certified in internal medicine and pulmonary diseases, and he began treating Claimant in November 1999 after he conducted an examination of Claimant in October 1999 at the request of the Department of Labor. DX 26.

Dr. Gregory J. Fino

Dr. Fino authored a report dated October 14, 2003 in which he noted that he examined Claimant on September 26, 2003. DX 69. He noted that Claimant was born 1934, was then 68 years old, and had smoked one pack of cigarettes per day for 32 years from 1955 until 1987. He also noted a history of 32 years of underground coal mine employment ending in 1982, that his last job in the mines was as a continuous miner operator, and that he had no past medical history of pneumonia, tuberculosis, asthma, bronchitis, or bronchiectasis.

Reported symptoms included breathing problems characterized by shortness of breath for 20 years which was getting worse but did not interfere with Claimant's usual daily activities. Claimant reported dyspnea when walking at his own pace on level ground or ascending one flight of steps, as well as when walking up hills or grades, lifting and carrying, performing manual labor, and walking briskly on level ground.

With respect to his physical examination, Dr. Fino noted that Claimant's lungs were clear to ausculation and percussion, and there were no wheezes, rales, rhonchi or rubs on forced expiratory maneuver. A chest x-ray was obtained which revealed no pleural or parenchymal abnormalities consistent with an occupationally acquired pneumoconiosis, although the film was classified as 2/1, q/t, 6 zones with bilateral pleural-based masses. Spirometry revealed moderate obstruction with bronchodilator response, normal lung volume with air trapping present, and normal diffusing capacity, oxygen saturation, and carboxyhemoglobin level. Arterial blood gases were also normal.

Dr. Fino noted that he reviewed various medical and other records. Under the heading "Diagnoses and Discussion," he concluded that Claimant had two risk factors for lung disease, *i.e.*, 30 years of coal dust exposure ending in 1982 and his 32 pack-year smoking history, ending in 1987. He found the first clear evidence of the development of an obstructive pulmonary condition was a pulmonary function study dated 11/8/89, and that subsequent pulmonary function studies showed a progressive obstructive abnormality with no evidence of a restrictive pulmonary deficit or emphysema.

Dr. Fino found unequivocal chest x-ray evidence of simple coal workers' pneumoconiosis which was the same on a 9/26/03 x-ray as it was on a 2/11/83 x-ray, but further

stated that Claimant's simple coal workers' pneumoconiosis could not explain the changes in lung function. According to Dr. Fino:

> This man clearly had significant coal dust in his lungs back in 1983; however, it had caused no abnormality in lung function. He has had no further coal dust exposure since 1982, but has had a worsening of his lung function. It is reasonable to assume that the amount of coal dust that he has in his lungs now, in 2003, is the same as he had 20 years ago. Since the amount of coal dust in the lungs is directly proportional to the amount of obstruction that one develops, one would assume that he should have had obstruction back in 1982 and 1983, if coal mine dust were the cause of the obstruction. In my opinion, the obstructive lung disease that is present is related to cigarette smoking. He continued to smoke until 1987 and this has caused the obstruction.

DX 69 at 13.

Dr. Fino noted that Claimant had developed significant lung masses over the years, but concluded they were not complicated coal workers' pneumoconiosis because there was no evidence of restrictive lung disease and no impairment in oxygen transfer based on diffusing capacities. He also stated that the changes shown on the 9/26/03 chest x-ray were not consistent with complicated coal workers' pneumoconiosis because the pattern shown in the x-ray was not typical of that disease. Based on his examination and evidence review, Dr. Fino concluded that Claimant was disabled due to cigarette smoking and not disabled by coal dust exposure.

Dr. Fino was deposed with respect to his opinions in this case on March 27, 2006. EX 2. He confirmed that he is Board-certified in both internal medicine and pulmonary disease, is a certified NIOSH B-reader, and received additional training in the reading and interpretation of x-rays and CT scans during his internship and residency. *Id.* at 5-8.

According to Dr. Fino, he previously prepared a report dated September 28, 2000 outlining his review of Claimant's medical records, and he later examined Claimant on September 26, 2003. *Id.* at 16. He reiterated his findings as a result of the 2003 examination and his conclusion that Claimant's moderate obstructive ventilatory impairment would prevent him from returning to work as a coal miner. *Id.* at 16-19. He further testified that such impairment was not caused by coal mine dust exposure but was, instead, a result of smoking and not coal workers' pneumoconiosis. *Id.* at 20-21.

Dr. Fino testified that Claimant's pulmonary function was normal in 1982 when he left the mines and the x-ray evidence of simple coal workers' pneumoconiosis in 1983 looked the same as it did in 2003 when Dr. Fino examined him. *Id.* at 21-22. He thus concluded that coal mine dust was an unlikely cause of Claimant's obstructive lung impairment. *Id.* at 22. He also noted that Claimant continued to smoke for an additional five years after he left the mines, and this factor, along with Claimant's normal diffusing capacity, led him to believe that the obstructive abnormality was caused by smoking. *Ibid*.

With respect to the more recent x-ray evidence, Dr. Fino testified that Claimant had developed "densities that are way out to the side of both lungs . . . [which] flat out doesn't look like complicated coal workers' pneumoconiosis . . . [because they are] too far lateral and they are not up high enough in the chest." *Id.* at 23-24. He stated that masses of this size, if they were complicated pneumoconiosis, would reduce the person's diffusing capacity, and he testified that had not happened in Claimant's case. *Id.* at 24.

Dr. Fino testified that the CT-guided needle biopsy was "very, very good for ruling in or ruling out a cancer, but it's very, very bad for trying to determine an abnormality within the lung tissue." *Id.* at 25. In this case, according to Dr. Fino, the multiple pieces of lung tissue totaling no more than five millimeters was insufficient to accurately make a diagnosis of any type of lung condition other than an infection or cancer. *Ibid*.

Dr. Fino reviewed medical reports of Drs. Erica Crouch and Joshua Perper, dated March 4, 2005 and December 27, 2005, respectively. *Id.* at 25. He agreed with Dr. Crouch's conclusion that the lung tissue obtained in Claimant's needle biopsy was insufficient to make any diagnosis, and he disagreed with Dr. Perper's conclusion that the large mass in Claimant's lung which was biopsied was complicated coal workers' pneumoconiosis. *Id.* at 26.

Dr. James R. Castle

According to a report dated April 5, 2004, Dr. Castle reviewed certain medical evidence and other documentation submitted to him by Employer's counsel. DX 89. Based on his review of this evidence, he opined that Claimant had simple coal workers' pneumoconiosis but not complicated coal workers' pneumoconiosis. *Id.* at 29. He noted that Claimant's 30 years of underground coal mining, ending in 1982, was sufficient to cause coal workers' pneumoconiosis in a susceptible host, but also stated that his history of smoking for 32 pack years, as reported by Dr. Fino, or for 25 pack-years, as noted by him in 2000, was "sufficient enough to have caused [Claimant] to develop chronic obstructive pulmonary disease, *i.e.*, chronic bronchitis/ emphysema and/or lung cancer and/or atherosclerotic cardiovascular disease if he were [a] susceptible host." *Id.* at 30. He noted that coronary artery disease was also a risk factor for the development of pulmonary symptoms and stated that Claimant had electrocardiogram findings which were "very suggestive of coronary artery disease with cardiac ischemia." *Ibid*.

Dr. Castle concluded that Claimant had "unequivocal radiographic evidence consistent with simple coal workers' pneumoconiosis" but stated that the radiographic characteristics of the pleural based masses seen after 1989 were consistent with granulomatous disease which he deemed to be "the most likely etiology of these pleural based masses." *Ibid*. He further found that the radiographic evidence was inconsistent with complicated coal workers' pneumoconiosis and that physiologic studies after 1989 exhibited progressive development of a partially reversible obstructive airways disease without restriction or diffusion abnormality. *Id.* at 30-31.

Based, *inter alia*, on his lack of exposure to coal dust after 1982, the absence of any pulmonary impairment for the next five to seven years, his continued smoking until 1987 or 1988, and the lack of any evidence of a mixed, irreversible obstructive and restrictive ventilatory

defect, Dr. Castle opined within a reasonable degree of medical certainty that Claimant's pulmonary disability "developed entirely due to his previous tobacco abuse." *Id.* at 31.

Dr. Castle took issue with the diagnosis of complicated coal workers' pneumoconiosis based on the needle biopsy directed by CT scan obtained in late 2003. He stated that "[t]he description of the pathologist does not meet pathologic standards for a diagnosis of either simple or complicated coal workers' pneumoconiosis." *Id.* at 31. He further noted that anthracotic pigmentation may be found in coal miners, urban dwellers, heavy tobacco smokers, and others in addition to those who suffer from coal workers' pneumoconiosis.

Based on all the evidence, Dr. Castle concluded that Claimant was permanently and totally disabled due to tobacco smoke induced airway obstruction with chronic asthmatic bronchitis. *Id.* at 32. He further concluded that Claimant was not disabled due to coal workers' pneumoconiosis. *Ibid*.

According to the curriculum vitae attached to his report, Dr. Castle is Board-certified in internal medicine and pulmonary disease and is a NIOSH certified B-reader.

Dr. Castle was deposed with respect to his conclusions in this case on January 6, 2006. EX 1. He noted that he had previously testified in this matter on August 30, 1991, October 26, 1994, and December 13, 2000, and he confirmed that he is a current NIOSH certified B-reader. *Id.* at 5.

Dr. Castle reiterated his prior findings from the examination of Claimant he conducted in May 2000, and he testified that since that examination he had reviewed additional evidence and prepared a report dated April 5, 2004 in which he set forth his conclusions. *Id.* at 6-7. Subsequent to the preparation of that report, Dr. Castle also reviewed the January 4, 2005 report of Dr. Erika Crouch. *Id.* at 8. None of the evidence he reviewed since 2000 would cause him to change his opinion that Claimant has a moderate obstructive lung disease with reversibility, that he does not have any restrictive lung disease, that he does not have any diffusion capacity impairment, and that he does not have any oxygen transfer impairment. *Id.* at 9-11. He continues to believe that Claimant suffers from simple, but not complicated, coal workers' pneumoconiosis. *Id.* at 12.

With regard to lesions observed in Claimant's lungs on the x-rays he reviewed, Dr. Castle testified:

> Now, he does have some airways areas of scarring that, from a standard chest x-ray, may give the appearance of masses, but when we look at the other data, primarily the CT Scan reports, we find that these are not typical central masses that are seen in CWP.
>
> The Scans have shown that these are pleural based masses that have developed subsequent to 1989, and these pleural based masses contain calcifications that are associated with hilar adenopathy or hilar lymph nodes with calcification as well.

> On at least one CT scan, there was a calcified granuloma in the spleen, so it tells me, based upon the appearance, the location, and the calcification, that these are pleural based attachments associated with scar tissue due to granulomatous disease, including some in the spleen, such as would be seen with something like histoplasmosis.

Id. at 12-13. According to Dr. Castle, the calcification is a result of scarring in the lung some of which then moved via the bloodstream to the spleen. *Id.* at 13. This process, he stated, "happens with certain types of infections such as tuberculosis and some . . . fungi like histoplasmosis, so it is very good evidence of a fungus being present in the lungs and in the lymphatic tissue of this man." *Id.* at 13-14.

Dr. Castle continues to believe that Claimant is disabled as a result of his respiratory impairment, but he further believes that such disability is not due to either coal mine dust exposure or coal workers' pneumoconiosis. *Id.* at 14-15. In his opinion, Claimant "has tobacco smoke-induced airway obstruction with a very significant asthmatic component or asthmatic bronchitis." *Id.* at 15. Dr. Castle would not expect to see the same degree of reversibility in obstruction if the impairment was due to coal mine dust exposure. *Id.* at 16. Furthermore, according to Dr. Castle, Claimant's ventilatory function when he left mining was normal until 1989, and he "would certainly expect to see impairment if it were going to occur at a much earlier level than what this gentleman showed [*i.e.*, not nine or ten years after cessation of exposure to coal dust]." *Id.* at 17. Although he acknowledged that coal workers' pneumoconiosis can be both latent progressive, Dr. Castle concluded that there was no evidence in this case to suggest that Claimant had either a latent or progressive form of that disease. *Id.* at 18.

Dr. Erika C. Crouch

According to a January 4, 2005 report by Dr. Crouch, she reviewed two glass slides and the corresponding surgical pathology report, along with miscellaneous medical and occupational records pertaining to Claimant, at the request of Employer's counsel DX 106. Her report notes:

> The biopsy shows a small fragment of dense hyalinized fibrous tissue with associated dust particles consistent with coal dust. However, there is no surrounding lung parenchyma and the biopsy is considered non-contributory with respect to assessing the absence or presence of pneumoconiosis. Such changes could occur in association with a coal dust micronodule or larger lesion, particularly if associated with coal dust containing crystalline silica. However, similar changes could result from non-specific entrapment of coal dust in other areas of scarring, including fibrosis resulting from old infectious or other granulomatous disease. Although some radiographic reports interpreted changes as most consistent with coal workers' pneumoconiosis, others noted atypical features and included chronic granulomatous disease in the differential. This pathologic study does not adequately distinguish between these possibilities.

> Thus, it is not possible to assess the possible contributions of coal dust exposure to any known respiratory impairment or disability.

Ibid.

The curriculum vitae attached to Dr. Crouch's report notes that she is a Board-certified pathologist.

Dr. Joshua A. Perper

Dr. Perper authored a medical report dated December 27, 2005 at Claimant's request after reviewing various medical records, documents, and biopsy slides. CX 2. He notes the documents he reviewed show, *inter alia*, an occupational history of coal mining ranging from 30 to 32 years, a smoking history ranging from 15 to 32 pack-years, chest x-rays from 2002 and 2003 read by various physicians as showing no pneumoconiosis up to complicated pneumoconiosis, a negative test for antibodies to histoplasma from May 13, 2003, and pulmonary function tests ranging from normal to a moderate obstructive defect. He further notes that his review of the lung biopsy slides revealed, *inter alia*, fragments of fibro-hyalino-anthracotic tissue with dense anthracotic pigmentation with presence of birefringent silica crystals resulting in a diagnosis of "[f]ibro-hyaline-anthracotic tissue consistent with complicated coal workers' pneumoconiosis." *Id.* at 22-23.

Dr. Perper concluded that Claimant suffers from "significant and severe complicated coal workers' pneumoconiosis" based on his 30+ years of exposure to coal dust, his symptoms of worsening shortness of breath over the years with objective signs of abnormal breathing sounds, obstructive pulmonary defects and hypoxemia, his x-ray evidence, and his lung biopsy evidence.

With respect to the x-ray evidence, Dr. Perper noted that the "vast majority of chest x-ray readers recognized the presence of pulmonary opacities diagnostic of simple coal workers' pneumoconiosis." *Id.* at 24.

He disagreed with the physicians who opined that the large lesions ranging from 2 cm to 5 cm seen in the x-rays were caused by a process other than complicated coal workers' pneumoconiosis, such as tuberculosis, fungal disease, sarcoidosis, asbestosis, Wegener's disease, or metastases. He found these alternative diagnoses unacceptable because: (1) serological tests for tuberculosis and fungal disease were negative; (2) cultures of sputum for tuberculosis were negative; (3) fungal diseases do not usually grow to large pulmonary masses and, when they do, they are accompanied by significant respiratory and/or systemic symptoms; (4) large tuberculous masses and Wegener's disease are also accompanied by significant respiratory and/or systemic symptoms and tuberculous masses frequently show cavitation; (5) the x-rays did not show butterfly-like hilar lesions which are typical of sarcoidosis; and (6) Claimant has no history of any significant exposure to asbestos. *Id.* at 25.

According to Dr. Perper, sub-pleural lesions, such as those seen in Claimant's x-rays, "are by no means rare, and often merge with the pleura." *Ibid*. He noted that, "[i]n this case the

masses were recognized as sub-pleural, i.e., extending below the pleura, and their size of up to 5 cm (2") clearly indicates a significant involvement of the lung proper." *Ibid*.

Dr. Perper also disagreed that coal workers' pneumoconiosis always presents as a combined restrictive/obstructive pulmonary disease, noting that it can present equally as an obstructive disease only, a restrictive disease only, or a combined restrictive/obstructive disease. *Ibid*.

With respect to the lung biopsy, Dr. Perper concluded that it substantiated the findings of severe fibro-hyaline-anthracosis with the presence of birefringent silica crystals consistent with complicated coal workers' pneumoconiosis. *Ibid*. He disagreed with Dr. Crouch's conclusion that it was not possible to assess the possible contributions of coal dust exposure to Claimant's respiratory impairment because, *inter alia*, his findings of marked anthracotic pigmentation with birefringent silica crystals in the biopsy samples "exclude the possibilities raised by Dr. Crouch of 'Non specific entrapment of coal dust in other areas of scarring including fibrosis resulting from old infectious or other granulomatous disease.'" *Id.* at 26-27. He also noted that Dr. Crouch's suggestion that the biopsy could have been taken from a pneumoconiotic micronodule instead of the large mass in Claimant's lung was "incorrect, because the lung biopsy was taken under CT guidance from a large pneumoconiotic mass." *Id.* at 27.

Dr. Perper noted that exposure to coal dust mixed with silica may result in the development of centrilobular emphysema as documented by various scientific studies. He similarly recognized that centrilobular emphysema is a known complication of smoking, and acknowledged that Claimant was a smoker until 1988. *Ibid*.

Based on his review of all the evidence, Dr. Perper concluded that coal workers' pneumoconiosis was a substantial cause of Claimant's pulmonary impairment and disability. *Id.* at 28. Among the findings he relied on in reaching this conclusion were: Claimant's shortness of breath, cough, and other respiratory symptoms; his worsening pulmonary and radiological findings; radiologic evidence of complicated coal workers' pneumoconiosis consisting of large masses exceeding 5 cm on a background of simple coal workers' pneumoconiosis; and biopsy results consistent with complicated coal workers' pneumoconiosis.

CT Scans

A report of a chest CT scan obtained on November 13, 2003 notes an impression by Dr. John R. McClane of multiple bilateral nodules, majority of which are pleural-based showing interval increase in size and extent since September 13, 2000. DX 77. He further noted that the changes were "probably secondary to chronic interstitial pulmonary disease such as coal workers' pneumoconiosis [with possibility of malignant transformation suggested by interval increase in size of lesions]."

According to a June 30, 2004 report of Dr. William Scott, Jr., the November 13, 2003 CT scan of Claimant's chest revealed, *inter alia*, a 5 x 3 cm mass in the lateral right upper lung adjacent to the pleura which contained calcifications and a slightly smaller peripheral mass at a lower level on the left, also with calcifications. DX 97. Dr. Scott concluded that there was no

background of small, rounded opacities in the lungs and the changes noted in the scan were most likely tuberculosis, unknown activity, at least partially healed.

Dr. Paul S. Wheeler also reviewed Claimant's November 13, 2003 CT scan and concluded in a report dated June 29, 2004 that Claimant did not have either simple or complicated coal workers' pneumoconiosis because the scan revealed a "very low profusion" of nodules in the background and the large masses seen in the scan were "peripheral involving pleura." DX 97.

A report of a chest CT scan obtained on December 11, 2003 signed by Dr. Nancy Hallo notes that a scan of the thorax was performed preliminary to Claimant's CT-guided lung biopsy and that the scan demonstrated multiple pleural-based masses and nodules in both lungs with no significant change compared to the last exam. DX 77. The report further notes that a CT-guided needle biopsy of a large pleural-based lesion in the lateral peripheral aspect of the right upper lobe produced four core biopsy specimens which demonstrated small fragments of pinkish-gray tissue as well as fragments of black crumbly material.

Biopsy

A right lung biopsy was performed at Clinch Valley Medical Center on December 11, 2003 by Dr. German Iosif. DX 77. The gross description in the report noted a container labeled "right lobe mass" with five elongated tan to dark gray-black cylindrical soft tissue fragments ranging from 0.4 to 1.1 cm in length. The microscopic description noted two short segments of amorphous hyalinized tissue infiltrated by brown carbon pigment with adjacent small segments of adipose tissue and striated muscle. The microscopic description further noted that "[n]o preserved lung tissue is present." There was no evidence of malignancy and the hyalinized segment was infiltrated by chronic inflammatory cells. The final diagnosis was "[s]egments of hyalinized material with carbon pigment accumulation consistent with anthracotic nodule (coal nodule)."

Conclusions of Law

Date of Filing and Timeliness

In order to be timely, a claim under the Act must be filed within three years after a medical determination of total disability due to pneumoconiosis has been communicated to the applicant. 20 C.F.R. § 725.308(a). There is a rebuttable presumption that every claim for benefits is timely filed. 20 C.F.R. § 725.308(c). A subsequent claim is not barred by the three year limitations period despite the existence of a medical report showing total disability dated beyond that period. *See, e.g.*, *Consolidation Coal Co. v. Director, OWCP [Williams]*, ___ F.3d ___, Case No. 05-2108 (4th Cir. July 13, 2006) (miner's subsequent claim not barred by the three year statute of limitations despite existence of evidence supporting entitlement submitted in conjunction with prior denied claim); *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358 (4th Cir. 1996) (same). A request for modification may be sought at any time before one year from the date of the last payment of benefits or at any time before one year after the denial of a claim. 20 C.F.R. § 725.301(a)(2000).

Claimant filed a subsequent claim for benefits under the Act on August 25, 1999. DX 1. The claim was subsequently found to be timely, but it was denied on the merits by Judge Neal in a decision dated June 28, 2001. DX 43. That decision was later affirmed by the Benefits Review Board on June 28, 2002. DX 56. Claimant thereafter filed a request for modification less than one year later on June 5, 2003. DX 54.

Employer has cited no evidence in support of its assertion that the instant claim is untimely, and my review of the record has failed to uncover any such evidence. I thus find the August 25, 1999 subsequent claim and the June 5, 2003 request for modification filed by Claimant in this case are timely.

Length of Coal Mine Employment

In her June 28, 2001 decision denying Claimant's application for benefits, Judge Neal concluded that Claimant was employed as a coal miner for thirty years based on her review of the evidentiary record. DX 43 at 15. Based on my review of the record, I concur in Judge Neal's finding. Accordingly, I find that Claimant was employed as a miner for 30 years.

Responsible Operator

The Director has determined that Dominion Coal Corporation was the most recent operator that met all of the requirements of the regulations. DX 18. Claimant's Social Security Earnings Record reflects that Claimant was employed by Dominion Coal Corporation from 1977 through 1982, and there is no subsequent coal mine employment listed. DX 4. I thus find that Dominion Coal Corporation is the properly named responsible operator in this case.

Dependents

The August 25, 1999 subsequent claim filed by Claimant shows that he married Georgia Bartley on June 19, 1962. DX 1. A marriage certificate submitted with his prior claim confirms Claimant's marriage on that date. DX 6. At the time of his October 19, 2000 hearing before Judge Neal, Claimant's wife Georgia was alive and residing with Claimant. DX 36 at 15. In a letter filed by Claimant on August 2, 2001, he stated that his wife was then in the hospital and was given less than a month to live. DX 46. In a letter dated July 10, 2003, Claimant stated that his wife died on October 3, 2001. DX 59. According to correspondence and a marriage certificate submitted by Claimant on January 4, 2006, Claimant married his present wife, Lucille Leonard Osborne, on October 26, 2005. CX 1. I thus find that between August 25, 1999 and October 3, 2001, as well as since October 26, 2005, Claimant has had one dependent for purposes of augmentation of benefits under the Act.

Standard of Review

The administrative law judge need not accept the opinion of any particular medical witness or expert, but must weigh all the evidence and draw his/her own conclusions and inferences. *Lafferty v. Cannelton Industries, Inc.*, 12 B.L.R. 1-190 (1989); *Stark v. Director, OWCP*, 9 B.L.R. 1-36 (1986). The adjudicator's function is to resolve the conflicts in the

medical evidence; those findings will not be disturbed on appeal if supported by substantial evidence. *Lafferty, supra; Short v. Westmoreland Coal Co.*, 10 B.L.R. 1-127 (1987); *Piccin v. Director, OWCP*, 6 B.L.R. 1-616 (1983).

In considering the medical evidence of record, an administrative law judge must not selectively analyze the evidence. *See Wright v. Director, OWCP*, 7 B.L.R. 1-475 (1984); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984); *Crider v. Dean Jones Coal Co.*, 6 B.L.R. 1-606 (1983); *see also Stevenson v. Windsor Power House Coal Co.*, 6 B.L.R. 1-1315 (1984). The weight of the evidence, and determinations concerning credibility of medical experts and witnesses, however, is for the administrative law judge. *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986); *Brown v. Director, OWCP*, 7 B.L.R. 1-730 (1985); *see also Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Henning v. Peabody Coal Co.*, 7 B.L.R. 1-753 (1985).

As the trier-of-fact, the administrative law judge has broad discretion to assess the evidence of record and determine whether a party has met its burden of proof. *Kuchwara v. Director, OWCP*, 7 B.L.R. 1-167 (1984). In considering the evidence on any particular issue, the administrative law judge must be cognizant of which party bears the burden of proof. Claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. *See White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Modification of Subsequent Claim

This case involves a request for modification of the subsequent claim filed by Claimant on August 25, 1999 which was finally denied by the Board's June 28, 2002 decision.[11] In such a case, the administrative law judge is required to conduct an independent assessment of the evidence submitted in support of modification, along with the evidence introduced in the subsequent claim, to determine whether such evidence is sufficient to establish a material change in conditions. *See, e.g.*, *Kingery v. Hunt Branch Coal Co*., 19 B.L.R. 1-6 (1994). The United States Supreme Court determined in *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 257 (1971) that all evidence of record should be reviewed in determining whether "a mistake in a determination of fact" was made. The Court further noted that the fact-finder is vested "with broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." *Id*. This requires an independent assessment of the newly submitted evidence considered in conjunction with the previously submitted evidence to determine whether the weight of that evidence is sufficient to satisfy an element of entitlement which was previously adjudicated against Claimant. *See Kingery, supra*. In *Jessee v. Director, OWCP*, 5 F.3d 723 (4th Cir. 1993), the Fourth Circuit determined that a request for modification may be based upon an allegation "that the ultimate fact – disability due to pneumoconiosis – was mistakenly decided . . . ." The Fourth Circuit has further held that "the modification procedure is flexible, potent, easily invoked, and intended to secure 'justice under the act.'" *Betty B Coal Co. v. Director, OWCP*, 194 F.3d 491, 497-498 (4th Cir. 1999).

[11] Claimant's request for modification was filed on June 5, 2003, more than 60 days after the Board affirmed Judge Neal's decision on June 28, 2002. The Board's decision was thus "final" prior to Claimant's timely filing of his request for modification. *See* 20 C.F.R. § 802.406 (Board decision final 60 days after issuance unless timely petition for review or request for reconsideration filed).

As noted above, Claimant's subsequent claim, filed August 25, 1999, was denied by Administrative Law Judge Mollie Neal on June 28, 2001. Judge Neal expressly found that Claimant was not entitled to the irrebuttable presumption relating to complicated coal workers' pneumoconiosis contained in 20 C.F.R. § 718.304 based on her conclusion that "all the newly submitted physician reports and the x-ray reports . . . [are] insufficient to show that the Claimant's pneumoconiosis has progressed to the stage of complicated pneumoconiosis." DX 43 at 16. She further determined that "all the physician opinions and the objective medical data each physician relied upon in support of his opinion . . . [was] equally probative on the issue of whether the miner's disability is due to coal dust inhalation or coal mine employment." *Id.* at 17. She thus found that Claimant had failed to satisfy his burden of proof under § 725.309 that there had been a material change in his condition since his original claim had been denied. *Ibid*. Judge Neal's decision was affirmed by the Benefits Review Board on June 28, 2002. DX 56. To prevail in his request for modification under § 725.310, Claimant must thus show by evidence submitted since June 28, 2002 that he suffers from complicated coal workers' pneumoconiosis or is totally disabled because of pneumoconiosis *or* that Judge Neal's decision was the result of a mistake in a determination of fact based on a review of the entire evidentiary record.[12]

A. *Complicated Pneumoconiosis*.

Under 20 C.F.R. § 718.304, there is an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis if the miner is suffering from complicated pneumoconiosis. Complicated pneumoconiosis is established by x-rays classified as Category A, B, or C, or by an autopsy or biopsy which yields evidence of massive lesions in the lung or nodules in the lung that would equate to a one centimeter or greater opacity on x-ray.[13] Despite the fact that the requirements relating to establishing complicated pneumoconiosis are stated in the disjunctive, I am required to consider all relevant evidence when determining whether a claimant has complicated pneumoconiosis. *Scarbro*, *supra*., 220 F.3d at 256 citing *Lester v. Director, OWCP*, 993 F.2d 1143, 1145 (4th Cir. 1993). As the Fourth Circuit has noted, "if evidence is available that is relevant to an analysis under prong (B) or prong (C) [of 30 U.S.C. § 921(c)(3)], then all of the evidence must be considered and evaluated to determine whether the evidence as a whole indicates a condition of such severity that it would produce opacities greater than one centimeter in diameter on an x-ray." *Id.* citing *Double B Mining, Inc. v. Blankenship*, 177 F.3d 240, 243-44 (4th Cir. 1999). The determination of whether the miner has complicated pneumoconiosis is a finding of fact, and the administrative law judge must consider and weigh all relevant evidence. *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250, 256 (4th Cir. 2000); *Melnick v. Consolid*a*tion Coal Co.,* 16 B.L.R. 1-31 (1991); *Maypray v. Island Creek Coal Co.*, 7 B.L.R. 1-683 (1985).

[12] As noted previously, after the District Director issued a June 8, 2004 proposed decision and order granting Claimant's request for modification, Employer's counsel submitted additional evidence and requested modification. DX 92, 97. My review of the evidence pursuant to Claimant's request for modification necessarily encompasses Employer's request which, for all the reasons stated in this decision, will be denied.

[13] The regulation substantially replicates the provisions of the Act found at 30 U.S.C. § 921(c)(3)(A)-(C).

(1) Chest X-ray Evidence.

The chest x-ray evidence in the record at the time of Judge Neal's decision consisted of 11 readings of an October 14, 1999 x-ray and 5 readings of a May 22, 2000 x-ray. DX 43 at 9-11. Inasmuch as only 4 of the October 14, 1999 x-ray readings were positive for complicated pneumoconiosis, and none of the May 22, 2000 x-ray readings found complicated pneumoconiosis, Judge Neal properly determined that this evidence would not support a finding of complicated coal workers' pneumoconiosis under § 718.304(a) of the regulations.

The x-ray evidence submitted since Judge Neal's decision denying benefits consists of six readings of a February 5, 2002 x-ray and five readings of a March 24, 2003 x-ray. DX 54, 64, 68-70, DX 72-73, 81, 107. Of the six readings of the February 5, 2002 x-ray, four are positive for complicated pneumoconiosis. Of these four positive readings, three were by physicians who are both Board-certified radiologists and B-readers.[14] The two remaining physicians, Drs. Wheeler and Scott, are both dually-qualified and read the x-ray as negative for both simple and complicated pneumoconiosis. With respect to the five readings of the March 24, 2003 x-ray, three dually-qualified physicians[15] found complicated pneumoconiosis while two dually-qualified physicians read the film as completely negative for pneumoconiosis.

The Board has held that, as a general matter, it is proper to accord greater weight to the most recent x-ray evidence of record. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149(1989)(en banc); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541 (1984); *Tokarcik v. Consolidation Coal Co*., 6 B.L.R. 1-666 (1983). A seven-month period between x-ray studies is sufficient to apply the "later evidence" rule. *Tokarcik*, *supra*.; *Stanley v. Director, OWCP*, 7 B.L.R. 1-386.

Inasmuch as the majority of the interpretations of the two newly submitted x-rays are positive for complicated pneumoconiosis, and both of these x-rays post-date the prior x-ray evidence by more than seven months, I find that this evidence supports a finding of the disease pursuant to § 718.304(a) of the regulations.

(2) Biopsy Evidence.

As noted previously, Claimant underwent a CT-guided needle biopsy at Clinch Valley Medical Center on December 11, 2003. DX 77. The gross description reflected in the pathology report states that five elongated tan to dark gray-black cylindrical soft tissue fragments ranging in size from 0.4 to 1.1 cm in length were obtained from a "right lobe mass." The microscopic description of the biopsied tissue states that there were "two short segments of amorphous hyalinized tissue infiltrated by brown carbon pigment . . . [with adjacent] small segments of adipose tissue and striated muscle." *Ibid*. There was no evidence of malignancy detected, and

[14] As noted above, the qualifications of Dr. Dilip Patel are not contained in the record and his narrative x-ray report is not classified in accordance with § 718.102 of the regulations. I therefore accord this interpretation diminished weight.

[15] One of the 3 readings which were positive for complicated coal workers' pneumoconiosis was contained in a narrative report by Dr. Ramakrishnan which, as stated previously, categorizes the findings in accordance with § 718.102 of the regulations.

"the hyalinezed segment [was shown focally to be] infiltrated by chronic inflammatory cells." *Ibid*. The final diagnosis was "[s]egments of hyalinized material with carbon pigment accumulation, consistent with anthracotic nodule (coal nodule).

In a letter dated December 24, 2003, Dr. Iosif, who is Board-certified in pulmonary diseases and internal medicine, concluded that, based on the results of the above-described biopsy, as well as radiographic evidence and clinical testing which was negative for tuberculosis and fungal infection, Claimant had complicated coal workers' pneumoconiosis. DX 76. In relevant part, the letter further states:

> [T]here is no question in my mind that [Claimant] has large fibrotic conglomerates consistent with complicated Coal Workers' Pneumoconiosis. Diagnostic considerations of sarcoidosis, tuberculosis or whatever are just of no clinical and now no pathological basis.

Ibid.

Dr. Crouch, who is a professor of pathology and immunology at Washington University in St. Louis and a Board-certified pathologist, authored a one-page report dated January 4, 2005 in which she diagnosed: (1) dense hyaline fibrosis; (2) skeletal muscle and adipose tissue; and (3) no evidence of malignancy. DX 106. She expressly found that the biopsy samples contained "dense hyalinized fibrous tissue with associated dust particles consistent with coal dust." *Ibid*. Despite her diagnosis of "dense hyaline fibrosis," however, she concluded that the biopsy sample obtained on December 11, 2003 contained "no surrounding lung parenchyma and the biopsy is considered non-contributory with respect to assessing the absence or presence of pneumoconiosis." *Ibid*. She then went on to note that "[s]uch changes could occur in association with a coal dust micronodule or larger lesion, particularly if associated with coal dust containing crystalline silica . . . [or] result from non-specific entrapment of coal dust in other areas of scarring, including fibrosis resulting from old infectious or other granulomatous disease." *Ibid*. Dr. Crouch's report notes that she reviewed "the . . . surgical pathology report and miscellaneous medical and occupation records regarding [Claimant]," but she does not reveal what those records included.

Dr. Perper, who is a professor of pathology and epidemiology at, *inter alia*, the University of Miami, Florida, authored a thirty-six page report dated December 27, 2005 in which he described his findings and conclusions based on all the medical evidence of record including, *inter alia*, his review of the December 11, 2003 biopsy evidence. CX 1. His report expressly identifies the records and materials he reviewed in this case and gives an exhaustive description of the various findings and conclusions contained therein. *Id.* at 1-23. With respect to his review of Dr. Crouch's report, he noted that her microscopic pathological findings were "very similar to those noted in the original surgical pathology report . . . [although her diagnosis was different]." *Id.* at 22. Based on his own review of the biopsy samples, Dr. Perper found "fibro-hyalino-anthracotic tissue with dense anthracotic pigmentation with presence of birefringent silica crystals . . . ." *Id.* at 23. He concluded that these findings were consistent with complicated coal workers' pneumoconiosis. *Id.* at 23, 25.

During his deposition in this case, Dr. Fino testified that the CT-guided needle biopsy performed on December 11, 2003 was "very, very good for ruling in or ruling out a cancer, but it's very, very bad for trying to determine an abnormality within the lung tissue." EX 2 at 25. He testified that the small amount of lung tissue obtained during the biopsy was insufficient to accurately make a diagnosis of any type of lung condition other than an infection or cancer and thus agreed with Dr. Crouch. *Id*. at 25-26. He disagreed with Dr. Perper's conclusion that the biopsy supported a diagnosis of complicated coal workers' pneumoconiosis. *Id.* at 26. When asked whether the biopsy revealed evidence of simple coal workers' pneumoconiosis, he testified:

> Oh, from the biopsy? We know what the chest x-ray shows, so that's probably true. I don't disagree with that. But as to the presence of complicated pneumoconiosis or whether the pneumoconiosis was contributing to the disability, you have to look at the time line of studies over the last twenty-three years. And he has other things going on besides simple pneumoconiosis.

Id. at 26-27. Despite his concession that the needle biopsy supported a diagnosis of simple pneumoconiosis, he concluded that the large densities observed in the x-rays and CT scans in the lateral portions of the lungs, one of which was the source of the biopsy tissue, were "not due to coal mine dust." *Id.* at 27.

Dr. Castle similarly took issue with the diagnosis of complicated coal workers' pneumoconiosis based on the needle biopsy of December 11, 2003. He noted that the microscopic description in the biopsy report expressly stated that "no preserved lung tissue is present," and thus concluded that "[t]he description of the pathologist does not meet pathologic standards for a diagnosis of either simple or complicated coal workers' pneumoconiosis." DX 89 at 31.

In order for a diagnosis to qualify as "pneumoconiosis," there must be evidence that the lung tissue has reacted to any embedded coal deposits. Consequently, black pigment in the lungs, standing alone, does not constitute a finding of pneumoconiosis. On the other hand, observations of black pigment with associated fibrosis in the lung tissue would qualify as a diagnosis of the disease. While Drs. Perper and Iosif diagnosed complicated coal workers' pneumoconiosis based on the biopsy evidence, the conclusions of Drs. Crouch, Castle and Fino that the biopsy does not establish complicated pneumoconiosis are supported by the biopsy report's notation that "no preserved lung tissue is present" in the biopsy sample. DX 77. As Dr. Castle correctly concluded, a pathological diagnosis of pneumoconiosis cannot be made without an analysis of lung tissue. DX 89 at 31. Since the biopsy report notes that no parenchymal lung tissue was obtained as a result of the procedure, I find that the December 11, 2003 biopsy cannot establish the presence of complicated coal workers' pneumoconiosis pursuant to § 718.304(b) of the regulations.

(3) Other Evidence Relevant to Complicated Pneumoconiosis.

The evidentiary record includes numerous medical opinions relevant to the issue of complicated coal workers' pneumoconiosis, some of which were considered by Judge Neal and others which were introduced by the parties thereafter.

Employer's experts have consistently opined that the large opacities in Claimant's lung are not evidence of complicated coal workers' pneumoconiosis because of their location in the lung (pleural-based and peripheral) and because they are likely attributable to some other disease process such as granulomatous disease (including tuberculosis and histoplasmosis), exposure to asbestos, or malignancy.

For example, Drs. Wheeler and Scott, both of whom are Board-certified radiologists and B-readers, reviewed a May 22, 2000 CT scan and x-ray and concluded that the changes they saw were due to conglomerate granulomatous disease and/or tumor with no evidence of pneumoconiosis. DX 30. During his October 2, 2000 deposition, Dr. Wheeler repeatedly identified the opacities in the x-rays and CT scans as pleural, peripheral, and possibly asbestos-related, granulomatous, or metastases. DX 37. He later concluded that the large masses shown in Claimant's February 5, 2002, March 24, 2003, and September 26, 2003 chest x-rays were compatible with inflammatory disease more likely than cancer. DX 68, 70, 81. He read Claimant's November 13, 2003 CT scan as showing "masses up to 7 cm long in periphery both lungs involving pleura compatible with conglomerate granulomatous disease but I can't excluded metatases [sic] . . . ." DX 97. He found no evidence of pneumoconiosis, either simple or complicated. *Ibid*. According to a June 30, 2004 report by Dr. Scott, the November 13, 2003 CT scan of Claimant's chest revealed, *inter alia*, a 5 x 3 cm mass in the lateral right upper lung adjacent to the pleura which contained calcifications and a slightly smaller peripheral mass at a lower level on the left, also with calcifications. DX 97. Dr. Scott concluded that there was no background of small, rounded opacities in the lungs and the changes noted in the scan were most likely tuberculosis, unknown activity, at least partially healed. *Ibid*.

Dr. Templeton, who is a Board-certified radiologist and a B-reader, read Claimant's May 22, 2000 CT scan as "compatible with silicosis or coal workers' pneumoconiosis" but noted the peripheral pleural-based opacities were "unusual" and could be "granulomatous in nature (along with the calcified nodes), could possibly indicate malignancy – particularly with pleural implants and lung nodules – although the chronic nature of the case speaks against this." DX 33, 35.

Dr. Castle, unlike Drs. Wheeler and Scott, concluded based on his review of the medical evidence that Claimant had "unequivocal radiographic evidence consistent with simple coal workers' pneumoconiosis" but stated that the radiographic characteristics of the pleural-based masses seen after 1989 were consistent with granulomatous disease which he deemed to be "the most likely etiology of these pleural based masses." DX 89 at 30. He similarly testified during his deposition that the pleural-based masses he saw in the x-rays and CT scans contained calcifications which were the result of scarring due to granulomatous disease such as histoplasmosis or tuberculosis and "not typical central masses that are seen in CWP." EX 1 at 12-14. Dr. Castle is Board-certified in internal medicine and pulmonary disease, and he is a certified B-reader.

Like Dr. Castle, Dr. Fino, who is a B-reader and Board-certified in internal medicine and pulmonary disease, also found unequivocal chest x-ray evidence of simple coal workers' pneumoconiosis which was the same on a September 26, 2003 x-ray as it was on a February 11, 1983 x-ray. DX 69 at 13. He concluded, however, that the significant lung masses Claimant had developed over the years were not complicated coal workers' pneumoconiosis because there was no evidence of restrictive lung disease and no impairment in oxygen transfer based on diffusing capacities. *Ibid*. He also stated that the changes shown on chest x-rays were not complicated coal workers' pneumoconiosis because the pattern of the changes was not typical of that disease. *Id.* at 13-14.

In contrast to the various opinions of Employer's experts, Claimant's experts have consistently opined that the large opacities seen in the x-rays and CT scans are not the result of any granulomatous, fungal or similar disease processes and are instead the result of complicated coal workers' pneumoconiosis.

For example, Dr. Iosif, who has been Claimant's treating physician since October 1999 and is Board-certified in internal medicine and pulmonary diseases, concluded that Claimant's radiographic features were consistent with those of complicated coal workers' pneumoconiosis, stated that there were no other plausible explanations for the radiographic abnormalities, and said that "history and ancillary studies have ruled-out any alternative diagnostic considerations." DX 26, 54. In a letter dated May 15, 2003, Dr. Iosif wrote that a sample of Claimant's histoplasma antibody titers was negative for disease. DX 54. He further noted that Claimant had a negative reaction to an intermediate strength PPD (purified protein derivative tuberculin) injection in the right forearm. *Ibid*.[16] A right lung biopsy performed on December 11, 2003 by Dr. Iosif found no evidence of malignancy. DX 77. He subsequently wrote in a December 24, 2003 letter: "I have conducted extensive investigations for the possibility of tuberculosis or fungal infection with negative results and the patient indeed has no symptoms of active infection or inflammation." DX 76. He diagnosed Claimant with complicated coal workers' pneumoconiosis and found no clinical or pathological basis for diagnostic consideration of sarcoidosis, tuberculosis, or any other disease. *Ibid*.

Dr. Robinette, who is a B-reader and Board-certified in internal medicine and pulmonary disease, previously examined Claimant in 1989 and reviewed Claimant's medical records from 1985 to 1999. DX 38 at 2, 4-5, 10. He concluded that Claimant's x-rays showed coal workers' pneumoconiosis with axillary coalescence. *Id.* at 7. He saw no gross evidence of tuberculosis in Claimant's lungs, despite the question of tuberculosis raised by physicians based on the asymmetry of dust disposition and granulomatous reaction.[17] *Id.* at 16. He agreed that the large densities in Claimant's lungs are "probably more consistent with pleural based lesions than true parenchymal abnormalities" but testified that they "are classified using the 1980 ILO x-ray

[16] *See also* DX 26 at 5 (12/1/99 office note by Dr. Iosif stating "PPD skin site is nonreactive."); DX 1a (10/25/94 letter from Dr. J.P. Sutherland noting Claimant had a negative Tine test, which is a multiple puncture tuberculin skin test, "which showed no evidence of tuberculin infection."). Letters dated November 22, 1993 and December 2, 1993 establish that Dr. Sutherland had been Claimant's treating physician since 1983. DX 1a.

[17] Dr. Robinette testified during his deposition that, since 1990, he has been the Chest Physician for TB control in the Southwestern District of Virginia, which covers nine counties, and he runs the tuberculosis clinics in Buchanan and Wise Counties, Virginia. DX 38 at 3.

classification which has been done correctly in the more recent interpretations. It's part of the spectrum of pneumoconiosis." *Id.* at 25.

Dr. Perper, who is a forensic pathologist and professor of pathology, similarly disagreed with the physicians who have opined that the large lesions ranging from 2 cm to 5 cm seen in the x-rays were caused by any process other than complicated coal workers' pneumoconiosis, such as tuberculosis, fungal disease, sarcoidosis, asbestosis, Wegener's disease, or metastases. CX 2. He found these alternative diagnoses unacceptable based on his review of all the medical evidence because: (1) serological tests for tuberculosis and fungal disease were negative; (2) cultures of sputum for tuberculosis were negative; (3) fungal diseases do not usually grow to large pulmonary masses and, when they do, they are accompanied by significant respiratory and/or systemic symptoms; (4) large tuberculous masses and Wegener's disease are also accompanied by significant respiratory and/or systemic symptoms and tuberculous masses frequently show cavitation; (5) the x-rays did not show butterfly-like hilar lesions which are typical of sarcoidosis; and (6) Claimant has no history of any significant exposure to asbestos. *Id.* at 25.

After a review of all the medical opinion evidence, pro and con, I am persuaded for several reasons that the preponderance of this evidence supports a finding of complicated coal workers' pneumoconiosis. First, although Employer's experts have routinely attributed the large opacities in Claimant's lungs to one or another form of granulomatous disease, such as tuberculosis or histoplasmosis, Claimant has no history of such disease and tests performed by Drs. Iosif and Sutherland were negative for these disease processes. Second, these physicians repeatedly characterize the etiology of the large opacities they observed in equivocal terms such as "compatible with healed granulomatous disease or silicosis," "compatible with benign asbestos-related pleural plaques or granulomatous disease or tumors," "possible tb or sarcoid," "probably granulomatous disease," "granulomatous disease . . .the most likely etiology," and "most likely tuberculosis, unknown activity." DX 37 at 6, 7, 8, 10; DX 70; DX 81; DX 89 at 30; DX 97. These equivocal statements regarding the etiology of Claimant's large opacities diminish the weight of Employer's expert opinions.[18] Third, to the extent any of Employer's experts have suggested that the x-ray and CT scan findings were the result of a metastatic process, the report of the biopsy performed in December 2003, which Dr. Fino noted was "very, very good for ruling in or ruling out a cancer," expressly found no evidence of malignancy. Fourth, the probative value of the opinions of Drs. Scott and Wheeler, that Claimant does not

[18] In *Cooper v. Westmoreland Coal Co.,* BRB No. 04-0589 BLA (Mar. 28, 2005) (unpub.), the Board held that the presiding administrative law judge properly rejected medical opinions, including one by Dr. Wheeler, when he found that "equivocal identification of TB as the disease process that accounts for the markings that other physicians have identified as complicated pneumoconiosis diminishes [their] credibility." *Id*., slip op. at 3. Citing *Lester v. Director, OWCP,* 993 F.2d 1143 (4th Cir. 1993), the Board acknowledged that a claimant "bears the burden of establishing that the large opacities are caused by dust exposure." *Ibid*. However, it further noted that, under *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250 (4th Cir. 2000), "in order to resolve conflicting x-ray interpretations regarding the presence of complicated pneumoconiosis, the administrative law judge must assess the probative value of the x-ray readings in their entirety, rather than accepting them at face value." *Ibid*. In this vein, the Board agreed with the presiding judge that equivocal statements regarding etiology were not sufficient to outweigh the opinion of other physicians who concluded that a large opacity was coal dust related. *Ibid*. *See, also*, *Yogi Mining Co. v. Director, OWCP [Fife]*, Case No. 04-2140 (4th Cir. Dec. 7, 2005) (unpub.) (proper for administrative law judge to accord less weight to equivocal or speculative opinions regarding etiology of opacities measuring greater than one centimeter on chest x-ray especially in light of negative TB tests).

have even simple pneumoconiosis and that the x-ray evidence does not reveal a significant background of small opacities, is greatly diminished by a substantial amount of contrary medical evidence, including the multiple x-ray readings from 1973 forward by dually-qualified physicians showing a profusion of opacities in the lungs ranging from 2/1 to 2/3 and the concessions by Drs. Castle and Fino, both of whom are B-readers, that the x-rays reveal "unequivocal" evidence of simple coal workers' pneumoconiosis. Fifth, Claimant has no reported history of exposure to asbestos. Indeed, as the record clearly shows, Claimant's only occupational exposure to any air borne pollutant has been to coal dust during his 30 years of underground coal mining, and the attribution of any of the large opacities in Claimant's lungs to asbestos exposure is simply speculation and not substantiated by any record evidence. Finally, Dr. Iosif's opinion that Claimant has complicated coal workers' pneumoconiosis may properly be accorded additional weight based on the fact that he is Claimant's treating physician. *See*, *e.g.*, *Onderko v. Director, OWCP*, 14 B.L.R. 1-2 (1989). I note that he first began treating Claimant in November 1999, and most recently examined Claimant on May 15, 2003. Dr. Iosif conducted specific diagnostic tests which were negative for tuberculosis and histoplasmosis, and he subsequently established that the large mass biopsied in December 2003 was not malignant. Based on his four-year treatment of Claimant, the results of the various diagnostic tests he conducted, and his review of other relevant medical evidence including CT scans and chest x-rays, Dr. Iosif concluded that Claimant suffers from complicated pneumoconiosis. His opinion is well-documented and well-reasoned, and it expressly refutes the conclusions of Employer's experts that the large masses observed in Claimant's lungs are a result of tuberculosis, histoplasmosis, malignancy or some disease process other than complicated pneumoconiosis.

Based on all the foregoing reasons, I find that the weight of the medical opinion evidence supports a finding of complicated pneumoconiosis. I further find that the evidence relevant to this issue as a whole demonstrates that Claimant has complicated pneumoconiosis and is irrebuttably presumed to be totally disabled under 20 C.F.R. § 718.304. Claimant has thus demonstrated that one of the applicable conditions of entitlement has changed since the date upon which his prior claim was finally denied pursuant to 20 C.F.R. § 725.310.[19]

Entitlement Based on Entire Record

Pursuant to 20 C.F.R. § 725.309(d), once a claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, are binding on any party in the adjudication of the subsequent claim. I must therefore determine whether all the evidence of record, both new and old, demonstrates that Claimant suffers from pneumoconiosis which was caused, at least in part, by his coal mine employment, and which renders him totally disabled.

[19] I similarly find, for the reasons discussed, that the newly submitted evidence, when considered in the context of the evidence submitted in support of Claimant's August 25, 1999 subsequent claim, weighs in favor of a finding of complicated coal workers' pneumoconiosis and establishes a mistake of fact in the denial of such claim. *O'Keefe v. Aerojet-General Shipyards, Inc.*, *supra*., 404 U.S. at 257.

Pneumoconiosis

The presence of pneumoconiosis was first established in connection with Claimant's original claim for benefits filed on March 2, 1982. DX 1a. That finding has consistently been reaffirmed in subsequent claims. DX 1a; DX 43. After a review of the medical evidence submitted in the prior claim, as well as that filed in the instant claim, I find, for the reasons previously stated, that Claimant has established by a preponderance of the evidence that he suffers from both simple and complicated pneumoconiosis.

Causal Relationship of Pneumoconiosis

If a miner suffering from pneumoconiosis was employed for ten years or more in coal mining, there is a rebuttable presumption that his pneumoconiosis arose out of such employment. 20 C.F.R. §§ 718.203(b), 718.302. The relationship of Claimant's pneumoconiosis to his 30 years of coal mine employment was first established in connection with Claimant's original claim in 1982, and reaffirmed in subsequent decisions. DX 1a; DX 43. There is no evidence in the record which would rebut the presumption that Claimant's pneumoconiosis arose out of his more than 30 years of coal mine employment, and I thus find that Claimant's pneumoconiosis was caused by such employment.

Total Disability and Causal Relationship

As noted above, I have found that the evidence of record establishes that Claimant suffers from complicated pneumoconiosis. Applicable regulations provide an irrebuttable presumption of total disability due to pneumoconiosis where the miner is shown to be suffering from complicated pneumoconiosis. 20 C.F.R. §§ 718.204(b)(1), 718.304. I thus find that Claimant is totally disabled by pneumoconiosis which arose out of his more than 30 years of coal mine employment.

Conclusion

Because Claimant has established a material change in condition under § 725.310, and all of the necessary elements of entitlement, I conclude that he is entitled to benefits under the Act and regulations.

Commencement of Benefits

Benefits are payable in a living miner's claim beginning with the month of onset of total disability due to pneumoconiosis arising out of coal mine employment. 20 C.F.R. § 725.503(b). Where the evidence does not establish the month of onset of total disability, benefits are paid beginning with the month during which the claim was filed. *Ibid*. When benefits are awarded on modification, the date of the claim upon which modification is based serves as the earliest date from which benefits may be paid. *Garcia v. Director, OWCP*, 12 B.L.R. 1-24 (1988).

Since the evidence in this case does not establish the month of onset of total disability, I find that Claimant is entitled to benefits beginning August 1999, the month during which his subsequent claim was filed.

Attorneys Fee

No award of attorney's fees for services to Claimant is made herein since no application has been received. Thirty days are hereby allowed to Claimant's counsel for the submission of such application. His attention is directed to 20 C.F.R. §725.365 and §725.366 of the regulations. A service sheet showing that service has been made upon all parties, including Claimant, must accompany the application. Parties have ten days following the receipt of such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

Based on all the foregoing, it is hereby ordered that the claim of G. M. for benefits under the Act be, and hereby is, GRANTED.

It is further ordered that the request for modification of the District Director's proposed decision and order granting benefits filed by Employer, Dominion Coal Corporation, be, and hereby is, DENIED.

It is further ordered that Employer, Dominion Coal Corporation, shall pay to Claimant all benefits to which he is entitled under the Act, augmented by reason of his dependent spouses, as heretofore specified, commencing August 1999.

It is further ordered that Employer, Dominion Coal Corporation, shall reimburse the Secretary of Labor for payments made under the Act to G. M., if any, and deduct such amount, as appropriate, from the amount it is ordered to pay under the preceding paragraph.

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STEPHEN L. PURCELL
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and

the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).